ANNUAL BURDEN ESTIMATES

Instrument	Number of respondents	Number of responses per respondent	Average burden hours per response	Annual burden hours
Children's Bureau Disaster Information Collection Form	10	1	1	10
Family Violence Prevention and Services Program Disaster Information Collection Form	10	1	1	10
Office of Child Care Disaster Information Collection Form	7	1	2	14
Office of Head Start Disaster Information Collection Form	10	1	2	20
Runaway and Homeless Youth Program Disaster Information Collection Form	10	1	1	10
Future Program Office Disaster Information Collection Forms	40	1	1.5	60

Estimated Total Annual Burden Hours: 124.

Authority: 42 U.S.C. 68 Disaster Relief; 42 U.S.C. Section 5121; Pub. L. 113–5.

Mary B. Jones,

ACF/OPRE Certifying Officer.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Criteria for Determining Maternity Care Health Professional Target Areas

AGENCY: Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS).

ACTION: Final response.

SUMMARY: Section 332 of the Public Health Service Act (PHSA) directs the Department of Health and Human Services (HHS), through the Health Resources and Services Administration (HRSA), to identify Maternity Care Target Areas (MCTA), or geographic areas within health professional shortage areas that have a shortage of maternity care health professionals, for the purpose of providing maternity health care assistance to such health professional shortage areas. On September 21, 2021, the Health Resources and Services Administration (HRSA) published a **Federal Register** notice soliciting feedback on proposed criteria to be used to identify Maternity Care Target Areas (MCTAs). HRSA requested feedback on six proposed criteria for inclusion in a composite scale to identify MCTAs with the greatest shortage of maternity care health professionals: (1) Ratio of females ages 15–44 -to-full time equivalent maternity care health professional ratio; (2) percentage of females 15–44 with income at or below 200 percent of the federal poverty level (FPL); (3) travel time and distance to the nearest provider location with access to comprehensive maternity care services; (4) fertility rate; (5) the Social Vulnerability Index; and (6) four Maternal Health Indicators (pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, and prenatal care initiation in the first trimester). This notice summarizes and responds to the comments received during the 60-day comment period and presents the final criteria which will be used to identify and score MCTAs.

ADDRESSES: Additional information about MCTAs is available at *https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.*

FOR FURTHER INFORMATION CONTACT: Dr. Janelle McCutchen, Chief, Shortage Designation Branch, Division of Policy and Shortage Designation, Bureau of Health Workforce, HRSA, 5600 Fishers Lane, Rockville, Maryland 20857, *sdmp@hrsa.gov,* or 301.443.9156.

SUPPLEMENTARY INFORMATION: Section 332 of the Public Health Service Act (PHSA), 42 U.S.C. 254e, provides that the Secretary designate Health Professional Shortage Areas (HPSAs) based on criteria established by regulation. HPSAs are defined in section 332 to include (1) urban and rural geographic areas which the Secretary determines have shortages of health professionals, (2) population groups with such shortages, and (3) public or private medical facilities or other public facilities with such shortages. The required regulations setting forth the criteria for designating HPSAs are codified at 42 CFR part 5.

Section 332(k)(1) provides that the Secretary, acting through the Administrator of HRSA, identify shortages of maternity care services ''within health professional shortage areas.'' Section 332(k)(1) further requires HRSA to identify MCTAs and distribute maternity care health professionals within HPSAs using the MCTAs so identified. HRSA must also collect and publish data in the **Federal Register** comparing the availability and need of maternity care health services in HPSAs and must seek input from relevant provider organizations and other stakeholders.

In a September 21, 2021, **Federal Register** notice (86 FR 53324), HRSA requested feedback on six proposed criteria to identify MCTAs: (1) Ratio of females ages 15–44 -to-full time equivalent maternity care health professional ratio; (2) percentage of females 15–44 with income at or below 200 percent of the federal poverty level (FPL); (3) travel time and distance to the nearest provider location with access to comprehensive maternity care services; (4) fertility rate; (5) the Social Vulnerability Index; and (6) four Maternal Health Indicators (pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, and prenatal care initiation in the first trimester).

HRSA carefully evaluated and analyzed the comments received and used them to guide the development of the final MCTA criteria.

Comments on the Proposed Criteria for Identifying Maternity Care Target Areas

HRSA received 21 responses to the request for comments. Comments and responses are summarized below.

Health Care Capacity Factors

Summary of Comments

Population-to-Provider Ratio

All commenters supported the inclusion of a population-to-provider ratio and agreed with HRSA's proposal of a population ratio of females ages 15–44 -to-full time equivalent maternity care health professional ratio. However, several commenters questioned the use of only Obstetrician/Gynecologists (OB/GYNs) and Certified Nurse Midwives (CNMs) in the provider ratio and recommended the inclusion of family medicine physicians, physician assistants, and nurse practitioners. Specifically, one commenter indicated

''that a comprehensive system of maternity healthcare services is comprised of multiple types of care and considerations should be made for the inclusion of family medicine physicians in rural areas that deliver maternity care services.''

Response

HRSA appreciates the recommendation for the inclusion of additional provider types and recognizes the important contribution all of these professionals play in the delivery of obstetrics care. Currently, standardized nationwide data is not readily available outlining the number of hours that individual family medicine physicians, physician assistants, and nurse practitioners spend providing these services, and thus the agency would have no way of uniformly comparing the hours that these providers spend contributing maternity care services. HRSA recognizes the important role of these clinicians in the provision of maternity care and will continue to review the availability of these data points to determine if additional provider types may be incorporated into the MCTA scoring criteria in the future. We continue to welcome recommendations on nationally available data sets for the incorporation of these provider types into MCTAs. Until that data is readily available for inclusion, HRSA will proceed with the population-to-provider ratio as proposed.

Travel Time and Distance (TTD) to Nearest Source of Care (NSC)

HRSA proposed including a measure of travel time and distance (TTD) to the nearest source of care (NSC) with access to comprehensive maternity care services. All commenters supported the inclusion of TTD to NSC criteria but presented varied methodologies on how to implement and score the criteria. Some commenters were concerned with the TTD point scale outline in the proposed criteria and suggested that HRSA adjust and expand the scoring scale to provide points for facilities identified within the 30 minute/mile TTD. A separate commenter requested that, ''In terms of distance from comprehensive services, I would ask HRSA to clarify that as the distance from a site that has more than one or two on-staff OB/GYN.'' Another commenter indicated that TTD should be the largest weighted factor, as it relates to the geographic accessibility of services and is part of the assessment needed to fully address the MCTA statutory requirements

Response

Section 332(k)(5) of the PHSA defines 'full scope maternity care health services' as care provided during labor, birthing, prenatal care, and postpartum care, with no specification regarding the quantity of providers available at the facility. As to the comment regarding including points for distance less than 30 minute/mile, the United States currently lacks an established benchmark for timely access to a facility for obstetric care. However, the American College of Obstetricians and Gynecologist (ACOG) proposes a 30-mintue capability for decision-to-incision for emergency cesarean delivery.[1] HRSA will therefore retain its proposed approach.

In reference to the comment for the explicit definition of ''distance from a site that has more than one or two on-staff OB/GYN,'' HRSA will apply the current Primary Care HPSA NSC policy, which identifies the NSC based on the presence of a provider trained and licensed to provide the necessary care regardless of the number of providers at the location. In response to the comment regarding geographic accessibility, HRSA recognizes the importance of this measure and will retain it as proposed and continue to monitor this issue in the future.

Health Care Need Factors

HRSA proposed the use of four Maternal Health Indicators (pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, and prenatal care initiation in the first trimester).

Summary of Comments

Inclusion of Cigarette Smoking as Maternal Health Indicator

Several commenters suggested inclusion of a tobacco usage indicator. Commenters noted that smoking in the 3 months leading up to pregnancy can increase the risk of preterm birth and of adverse maternal health outcomes, and recommended inclusion of tobacco use as an indicator. Additionally, commenters highlighted that a significant proportion of women who smoked cigarettes prior to pregnancy continue to smoke into the later stages of gestation.

Response

HRSA agrees that the smoking of cigarettes is a significant risk factor for adverse maternal health outcomes and will add *cigarette smoking* as a Maternal Health Indicator. For this purpose, cigarette smoking will be defined as women who report smoking one or more cigarettes daily for the 3 months prior to pregnancy or during any of the trimesters of their pregnancy.

One point will be added if the prevalence of cigarette smoking before or during pregnancy in the MCTA is greater than or equal to the median among all counties in the United States. If the prevalence of cigarette smoking before or during pregnancy in the MCTA is less than the median among all counties, zero points will be added.

Cigarette smoking	Points
Prevalence of Cigarette Smoking Before or During Pregnancy ≥50th percentile	1
Prevalence of Cigarette Smoking Before or During Pregnancy <50th percentile	0

To accommodate the inclusion of this factor, one point will be removed from the total possible number of points awarded for the percent of the population living at or below the 200 percent Federal Poverty Level indicator. The rationale for this change is that household income relative to the federal poverty line is represented not only in this criterion but also in the Social Vulnerability Index criterion.

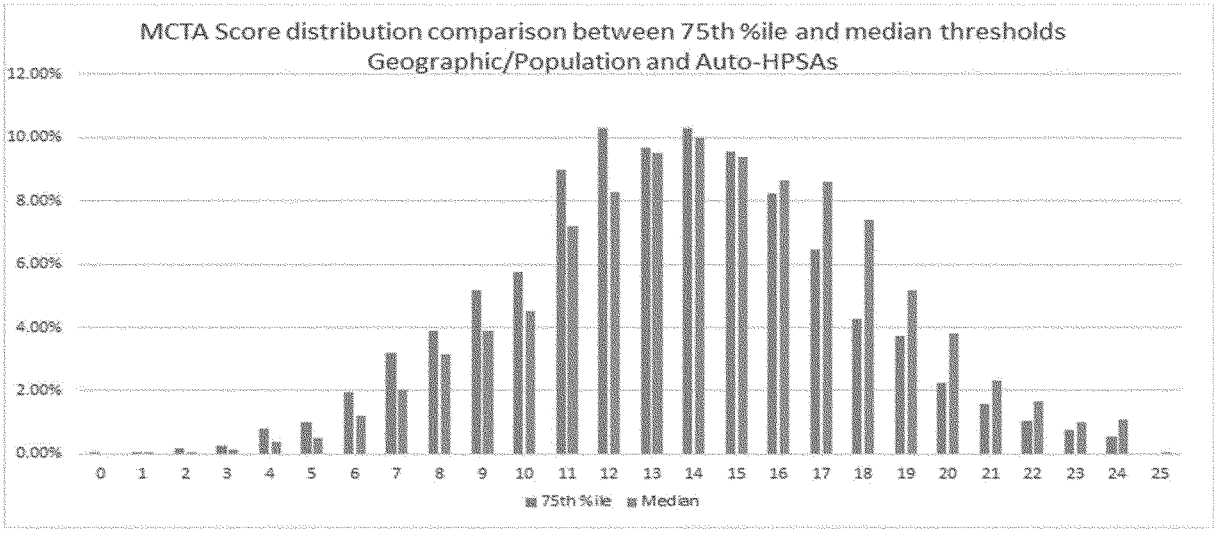
Lower Point Threshold for Maternal Health Indicators

HRSA proposed that the threshold for receiving points for Maternal Health Indicators would be 75%. Two commenters noted that the threshold to receive a point for the Maternal Health Indicators was ''too restrictive.'' One commenter recommended that the threshold be decreased for each indicator from the top quartile (75th percentile) to the median (50th percentile).

[1] 1Roa, Lina et al., ''Travel Time to Access Obstetric and Neonatal Care in the United States.'' *Obstetrics and Gynecology* (New York. 1953) vol. 136, no. 3 (2020): 610–612.

Response

HRSA conducted an impact analysis applying both percentiles to existing primary care HPSAs. The results of the analysis indicated that lowering the percentile threshold for Maternal Health Indicators to the median resulted in a slightly more standard distribution of the points across currently designated primary care HPSAs. The chart below provides a visual of the difference in the score distribution between the two thresholds. Based on this analysis, HRSA will adjust the threshold for the Maternal Health Indicators to reflect the 50th percentile recommendation of the commenters.



Social Vulnerability Index

Several commenters requested that HRSA provide points based on the individual factors of the Social Vulnerability Index (SVI) to allow for an increased impact of the social determinant factors within the SVI. Additionally, commenters proposed increasing the number of points allotted to the entire SVI.

Response

HRSA recognizes the importance of the SVI in the prioritization and distribution of resources. The scientific research that correlates the SVI to a need for additional health care resources was conducted using the entire index and not the individual factors. In addition, accommodating all 15 of the individual factors of the SVI would dilute the impact of Maternal Health Indicators that are more closely associated with the need for maternal health care. Increasing the weight of the SVI in the MCTA scoring criteria would decrease the impact of other factors, such as initiation of prenatal care and pre-pregnancy diabetes. HRSA will continue to apply the SVI as a whole to the MCTA scoring criteria and maintain the proposed point scale.

Inclusion of Behavioral Health Factor as Maternal Health Indicator

Several commenters recommended the inclusion of a behavioral health factor as part of the Maternal Health Indicators. One commenter specifically recommended a composite point based on prevalence of perinatal mood, anxiety disorders, and substance use disorder. Commenters highlighted that a pre-pregnancy diagnosis of a mental health illness can be an indicator of an increased risk of mental health concerns during pregnancy, which also increases the potential for adverse perinatal/post-partum health outcomes.

Response

HRSA recognizes the important impact of behavioral health factors on maternal health outcomes. A Report from the 14-state Maternal Mortality Review Committee found that 11% of the 421 pregnancy related deaths with an identified underlying cause of death determination, were due to mental health conditions. The Review Committee also determined that 100% of the pregnancy-related mental health deaths with a preventability determination were preventable.[2]

The Centers for Disease Control and Prevention (CDC) and Emory University conducted a cross-sectional multilevel analysis of all pregnancy-related deaths and all live births with available ZIP code or county data in the Pregnancy Mortality Surveillance System during 2011–2016 for non-Hispanic Black, Hispanic (all races), and non-Hispanic White women aged 15–44 years. Among health care need and service indicators, the number of mental health care professionals per 100,000 population had a strong inverse relationship with the pregnancy-related mortality ratio. Each standard unit increase in the number of mental health care professionals was associated with 5.55 (95% CI −8.11 to −2.99) fewer deaths per 100,000 live births among Black women and 1.42 (95% CI −2.08 to −0.76) fewer deaths per 100,000 live births among White women.[3]

HRSA agrees that access to behavioral health is a significant risk factor for adverse maternal health outcomes and will include a *behavioral health* access factor as a Maternal Health Indicator.

One point will be awarded if a portion or all of MCTA service area is designated as a Mental Health HPSA meeting the following population-to-provider median ratio thresholds based on its mental health provider type. Zero points will be awarded if a portion or all of the MCTA service area is not designated as a Mental Health HPSA or

[2] Trost, Susanna L., et al. ''Preventing Pregnancy-Related Mental Health Deaths: Insights from 14 US Maternal Mortality Review Committees, 2008–17: Health Affairs Journal.'' *Health Affairs,* 1 Oct. 2021, *https://www.healthaffairs.org/doi/10.1377/hlthaff.2021.00615.*

[3] Barrera, C., & Et.Al. (2022). County-Level Associations Between Pregnancy-Related Mortality Ratios and Contextual Sociospatial Indicators. *Journal Of Obstet Gynecol, 00*(00), 1–11.

the Mental Health designation does not meet the population to provider ratio threshold.

Behavioral health	Points
Portion or all of MCTA service area is designated as a Mental Health HPSA meeting the following population-to-provider ratio thresholds based on its mental health provider type • *Psychiatrist ONLY:* Psychiatrist population-to-provider ratio ≥45,000:1. • *Core Mental Health:* Core mental health population-to-provider ratio ≥18,000:1. • *Psychiatrist and Core Mental Health:* Psychiatrist population-to-provider ratio ≥35,000:1 and Core mental health population-to-provider ratio ≥6,000:1. • *No Psychiatrists or Core Mental Health Providers:* ≥7,500: 0.	1
Portion or all of MCTA service area is designated as a Mental Health HPSA and does *not* meet the population-to-provider ratio thresholds above, *OR* is not designated as a Mental Health HPSA	0

To accommodate the inclusion of this factor, one point will be removed from the total possible number of points awarded for the travel time and distance (TTD) to nearest source of care (NSC) criteria. The rationale for this change is to ensure that all Health Care Capacity Factors are equal in value.

Conclusion of Comment Response

HRSA appreciates the comments and recommendations received and has used them to guide the development of the final Maternity Care Health Professional Target Area criteria. Comments were not received on the proposed Federal Poverty Level or Fertility Rate factors; they will be finalized as proposed. The final MCTA criteria are included below. If you have any questions, please contact Dr. Janelle McCutchen at *sdmp@hrsa.gov.*

Final Approach for Determining Maternity Care Health Professional Target Areas

An MCTA score will be generated for each primary care HPSA using the HPSA's service area. The following six scoring criteria will be included in a composite scale that will be used to identify MCTAs with the greatest shortage of maternity care health professionals: (1) Ratio of females ages 15–44 -to-full time equivalent maternity care health professional ratio; (2) percentage of females 15–44 with income at or below 200 percent of the FPL; (3) travel time and distance to the nearest provider trained and licensed to provide the necessary care; (4) fertility rate; (5) the SVI; and (6) Maternal Health Index which contains the following six indicators: Pre-pregnancy obesity, pre-pregnancy diabetes, pre-pregnancy hypertension, prenatal care initiation in the first trimester, cigarette smoking, and the behavioral health factor. Each of these six criteria will be assigned a relative weight based on the significance of that criterion relative to all the others.

The weighted scores will be summed to develop a composite MCTA score ranging from zero to 25, with 25 indicating the greatest need for maternity care health professionals in the MCTA. Accordingly, the higher the composite score, the higher the degree of need for maternity care health services.

Score for Population-to-Full-Time-Equivalent Maternity Care Health Professional Ratio

Population-to-provider ratio will measure the number of women of childbearing age in the service area compared to the number of maternity care health professionals in the service area. Women of childbearing age will be defined as women between the ages of 15–44 years old and maternity care health professionals will be defined as OB/GYNs and CNMs. A population-to-provider ratio of 1500:1 will be used as a minimum requirement for a population to be considered reasonably served by OB/GYNs and CNMs.

Population-to-provider Ratio point values will be distributed as follows:

Population-to-provider ratio	Points
Ratio ≥6,000:1, or No CNMs or OB–GYNs and Population (Pop) ≥500	5
6,000:1 > Ratio ≥5,000:1, or No CNMs or OB–GYNs and Pop ≥400	4
5,000:1 > Ratio ≥3,000:1, or No CNMs or OB–GYNs and Pop ≥300	3
3,000:1 > Ratio ≥2,000:1, or No CNMs or OB–GYNs and Pop ≥200	2
2,000:1 > Ratio ≥1,500:1, or No CNMs or OB–GYNs and Pop ≥100	1
Ratio <1,500:1, or No CNMs or OB–GYNs and Pop <100	0

Score for Percentage of Population With Income at or Below 200 Percent of the Federal Poverty Level

The percentage of people living in the service area at or below 200 percent of the FPL will be used to score MCTAs, based on poverty data from the U.S. Census Bureau.

Population with income at or below 200 percent of the FPL point values will be distributed as follows:

Population with income at or below 200% FPL ratio	Points
Percentage of population with income at or below 200% FPL ≥50%	5
50% > Percentage of population with income at or below 200% FPL ≥45%	4
45% > Percentage of population with income at or below 200% FPL ≥40%	3
40% > Percentage of population with income at or below 200% FPL ≥35%	2
35% > Percentage of population with income at or below 200% FPL ≥30%	1
Percentage of population with income at or below 200% FPL <30%	0

Score for Travel Distance/Time to Nearest Source of Accessible Care Outside of the MCTA

The Nearest Source of Care is defined as the nearest provider trained and licensed to provide the necessary care, as determined by the ESRI StreetMap Premium road network. Travel Time and Distance is defined as the average time to travel by road miles or the actual distance in road miles to the nearest source of care.

Travel Time and Distance to the Nearest Source of Care point values will be distributed as follows:

Travel time and distance	Points
Time ≥90 min or Distance ≥90 miles	5
90 min > Time ≥75 min or 90 miles > Distance ≥75 miles	4
75 min > Time ≥60 min or 75 miles > Distance ≥60 miles	3
60 min > Time ≥45 min or 60 miles > Distance ≥45 miles	2
45 min > Time ≥30 min or 45 miles > Distance ≥30 miles	1
Time < 30 min and Distance <30 miles	0

Score for Fertility Rate

Fertility rate has been included to reflect the increased need for maternity care services among populations that experience a higher rate of births. Women of childbearing age will be derived from the American Community Survey and births will be derived from the National Vital Statistics System.

Fertility Rate point values will be distributed as follows:

Fertility rate	Points
Fertility Rate ≥90th Percentile	2
90th Percentile > Fertility Rate ≥50th Percentile	1
Fertility Rate <50th Percentile	0

Score for Social Vulnerability

Social vulnerability is defined as the resilience of communities when confronted by external hazards such as disasters or disease outbreaks per the Agency for Toxic Substances and Disease Registry's Geospatial Research, Analysis and Services Program within the Centers for Disease Control and Prevention. A score for overall social vulnerability will be incorporated into the MCTA composite score using the Centers for Disease Control and Prevention's SVI.

Social Vulnerability point values will be distributed as follows:

Social vulnerability index	Points
Social Vulnerability ≥75th Percentile	2
75th Percentile > Social Vulnerability ≥50th Percentile	1
Social Vulnerability <50th Percentile	0

Score for Maternal Health Indicators

Maternal Health Indicators are defined as factors associated with poor maternal health outcomes using data from the National Vital Statistics System and the Shortage Designation Management System. Scores will consider pre-pregnancy obesity, diabetes, hypertension, cigarette smoking, and whether prenatal care began in the first trimester as well as access to behavioral health services. Only women of childbearing age will be considered for these indicators. HRSA will use the National Vital Statistics System Natality file as the data source to determine the sub-score for pre-pregnancy obesity, diabetes, hypertension, cigarette smoking, and whether prenatal care began in the first trimester. The Shortage Designation Management System Mental Health Professional Shortage Area file will be the data source to determine the sub-score for the behavioral health access factor.

Maternal Health Indicator criteria point values will be distributed as follows:

Pre-pregnancy obesity	Points
Prevalence of pre-pregnancy obesity ≥50th percentile	1
Prevalence of pre-pregnancy obesity <50th percentile	0

- *Pre-Pregnancy Obesity*

Pre-pregnancy obesity is defined as having a Body Mass Index of 30 or higher. One point will be awarded if the prevalence of pre-pregnancy obesity in the area is greater than or equal to the 50th percentile among all counties in the United States. If the prevalence of pre-pregnancy obesity in the area is less than the 50th percentile among all counties, zero points will be awarded.

- *Pre-Pregnancy Diabetes*

One point will be awarded if the prevalence of pre-pregnancy diabetes in the area is greater than or equal to the 50th percentile among all counties in the United States. If the prevalence of pre-pregnancy diabetes in the area is less than the 50th percentile among all counties, zero points will be awarded.

Pre-pregnancy diabetes	Points
Prevalence of pre-pregnancy diabetes ≥50th percentile	1
Prevalence of pre-pregnancy diabetes <50th percentile	0

• *Pre-Pregnancy Hypertension*

One point will be awarded if the prevalence of pre-pregnancy hypertension among women in the area is greater than or equal to the 50th percentile among all counties in the nation. If the prevalence of pre-pregnancy hypertension among women in the area is less than the 50th percentile among all counties, zero points will be awarded.

Pre-pregnancy hypertension	Points
Prevalence of pre-pregnancy hypertension ≥50th percentile	1
Prevalence of pre-pregnancy hypertension <50th percentile	0

• *Cigarette Smoking*

One point will be awarded if the prevalence of cigarette smoking before or during pregnancy among women in the area is greater than or equal to the 50th percentile among all counties in the nation. Before pregnancy will be defined as smoking one or more cigarettes daily for the 3 months prior to pregnancy. During pregnancy will be defined as smoking one or more cigarettes during any trimester of pregnancy. If the prevalence of cigarette smoking before or during pregnancy among women in the area is less than the 50th percentile among all counties, zero points will be awarded.

Cigarette smoking	Points
Prevalence of Cigarette Smoking Before or During Pregnancy ≥50th percentile	1
Prevalence of Cigarette Smoking Before or During Pregnancy <50th percentile	0

• *Prenatal Care Initiation in the 1st Trimester*

One point will be awarded if the prevalence of women who did not initiate prenatal care in the first trimester of their pregnancy is greater than or equal to the 50th percentile among all counties in the nation. Zero points will be awarded if the prevalence of women who did not initiate prenatal care in the first trimester of their pregnancy is less than the 50th percentile among all counties.

Prenatal care in first trimester	Points
Prevalence of No Prenatal Care in First Trimester ≥50th percentile	1
Prevalence of No Prenatal Care in First Trimester <50th percentile	0

• *Behavioral Health Factor*

One point will be awarded if a portion or all of MCTA service area is designated as a Mental Health HPSA meeting the following population-to-provider median ratio thresholds based on its mental health provider type. Zero points will be awarded if a portion or all of the MCTA service area is not designated as a Mental Health HPSA or if the Mental Health designation does not meet the population to provider ratio threshold.

Behavioral health factor	Points
Portion or all of MCTA service area is designated as a Mental Health HPSA meeting the following population-to-provider ratio thresholds based on its mental health provider type • *Psychiatrist ONLY:* Psychiatrist population-to-provider ratio ≥45,000:1. *Core Mental Health:* Core mental health population-to-provider ratio ≥18,000:1. • *Psychiatrist and Core Mental Health:* Psychiatrist population-to-provider ratio ≥35,000:1 and Core mental health population-to-provider ratio ≥6,000:1. • *No Psychiatrists or Core Mental Health Providers:* ≥7,500: 0	1
Portion or all of MCTA service area is designated as a Mental Health HPSA and does not meet the population-to-provider ratio thresholds above, OR is not designated as a Mental Health HPSA	0

Paperwork Reduction Act

The criteria used to identify MCTAs under section 332(k) of the PHSA, as described in this announcement, will not involve data collection activities that fall under the purview of the Paperwork Reduction Act of 1995. If the methods for determining MCTAs fall under the purview of the Paperwork Reduction Act, HRSA will seek the Office of Management and Budget clearance for proposed data collection activities.

Carole Johnson,

Administrator.

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